DOCUMENT RESUME

ED 244 879 SO 015 678

AUTHOR Stambler, Moses
TITLE Health Education for Health Promotion in Less Developed Nations.
PUB DATE 84
NOTE 52p.
PUB TYPE Viewpoints (120)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Behavioral Objectives; Behavior Modification; Cognitive Development; *Community Involvement; Course Content; Curriculum Development; *Developing Nations; Elementary Secondary Education; *Health Education; *Prevention; Relevance (Education); School Community Relationship; Teacher Education

ABSTRACT

Designed for policy makers and health education professionals, this paper presents a rationale and strategies for adapting health education to meet the needs of developing nations. Emphasis is placed on the need for health promotion rather than prescriptive health education. Section A, the first of two main sections, discusses perceptions of health problems, biomedical components related to health care in less developed countries (demographic factors, malnutrition, unsanitary living conditions, and lack of medical care), weaknesses in USAID and other agency approaches to health education, and historical changes in the training and use of health personnel and resources. Eight health manpower objectives are presented. Section B considers changes from health education to health promotion. The role of the Alma Ata Conference (1978) in setting the stage for a participatory approach to health education, the relationship between behavior modification and health promotion, and policy reformulation priorities involved with health promotion are outlined. A chart illustrates differences between health education and health promotion. Non-formal and formal school-based health education programs, cognitive bias in traditional school health programs, social variables in health education, the role of teacher training institutes in developing teachers as health agents, and recommendations for curriculum innovation to incorporate the new health promotion approach are also considered. The Self Discovery Project developed in Georgia to incorporate the new involvement approach to health promotion is reviewed, as are similar programs in Tanzania and Brazil. (LP)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED244879

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Moses Stambler

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

HEALTH EDUCATION FOR HEALTH PROMOTION IN LESS DEVELOPED NATIONS

- Prof. Moses Stambler
- Southern Connecticut State University
- HSC 575 - International Health Policy
- Spring 1984

SØ 015 678

ABSTRACT

HEALTH EDUCATION FOR HEALTH PROMOTION IN LESS DEVELOPED NATIONS

by

Moses Stambler

Responses to health problems in less developed nations are contingent on different perceptions. Medical definitions of problems by USAID and other agencies are expanding to include structural and social dimensions. Also, there has been a historical change in health manpower development and allocation on the basis of problem perception and inclusion of the social dimension.

Conceptual changes from health education to health education promotion are affecting the handling of health problems. There is increased emphasis on community involvement and the uses of local formal/informal delivery systems. The traditional cognitive bias in health education programs is shifting to focus on behavioral approaches for health promotion. Curriculum changes and teacher training reflect these changes to more behavioral approaches.

A. PERCEPTION OF HEALTH PROBLEMS

1. DEFINITION OF PROBLEMS
2. USAID AND THE MEDICAL LIMITS OF THEIR PROBLEM DEFINITION
3. HEALTH PERCEPTIONS AND DEFINITIONS
4. HISTORICAL CHANGES OF HEALTH MANPOWER DEVELOPMENT AND ALLOCATION

B. CHANGES FROM HEALTH EDUCATION TO HEALTH EDUCATION PROMOTION

1. THE CHANGE
2. INSTITUTIONAL DELIVERY SYSTEMS; COMMUNITY ORIENTATION
3. INSTITUTIONAL DELIVERY SYSTEMS: NON-FORMAL AND FORMAL SCHOOL BASED HEALTH EDUCATION
4. COGNITIVE BIAS IN TRADITIONAL SCHOOL HEALTH EDUCATION PROGRAMS
5. LOCUS OF CONTROL AND OTHER SOCIAL VARIABLES
6. SCHOOL HEALTH - THREE COMPONENTS
7. A CURRICULUM TO EMBODY CURRENT BEHAVIORAL THINKING ON HEALTH EDUCATION
8. THE ROLE OF TEACHER TRAINING INSTITUTIONS IN DEVELOPING TEACHERS AS HEALTH AGENTS

INTRODUCTION

There is growing recognition of the importance of health education as contributor toward the goal of Health for all by the year 2,000. A 1983 report by the Committee of Experts - WHO (WHO, Expert Committee, 1983) suggests recognition for this dimension. What can be the most effective implementation of a health education approach? This depends on the perception of health problems and the changing definition of the concept'health education.' Shifts from medical to socio-cultural problem definitions and changes from traditional approaches of health education to health promotion education suggest new impetus to this dimension of improved health in developing nations.

A. PERCEPTION OF HEALTH PROBLEMS: A PROBLEM OF DEFINITION

Dealing with health problems in developing nations is contingent upon appropriate definitions of the problems involved.

On the one hand, these problems may be viewed in their bio-medical dimensions with the resultant bio-medical solutions. On the other hand, these problems may be defined in their broader socio-cultural contexts, an approach suggesting a health education and promotion dimension in an interrelated system.

Certainly the bio-medical dimension is accurate as a dimension for targeted medical cure and as and measure of positive change. However, we should recognize this as a symptomatic rather than causative dimension for health improvement. Health education can be an effective means of incorporating a socio-cultural and structural dimension to a traditional bio-medical perspective.

There are four major bio-medical components related to health.

These are: (Gillis, 241-51)

1. Demographic Factors -

Higher rates of maternal, infant and child mortality are associated with having been born into a family of several older siblings. "The additional deaths appear to result from strains which large families impose on various family resources, including income, food supply, and parental time and attention." (Gillis, 241)

2. Malnutrition - Primarily Protein - Calorie

This has its greatest effect among children and results in substandard physical development and can turn mild childhood diseases (respiratory problems, gastrointestinal difficulties, and measles) into killers.

- 3% of world children suffer from severe malnutrition and results in Kwashiorkor and Marasmus
- 25% of world children suffer from moderate malnutrition
- 40-45% of world children suffer from mild-first degree-malnutrition

3. Unsanitary Living Conditions Because of the Environment -

- Principal problem of environmental sanitation in LDC is contamination of the water supply

- Infectious, parasatic and respiratory diseases causing death and sickness in LDC are water-borne. (Typhus and dysentery are key examples)
- Poor housing and space ventilation arises in urban areas and promotes spread of air-borne diseases, such as tuberculosis.

4. Lack of Medical Care of Adequate Quantity, Quality and Type

4.1 Poorly distributed and too few health services

4.2 Non-functioning referral system

4.3 Imbalance between curative and preventive efforts and services

2. (US)AID AND THE MEDICAL LIMITS OF THEIR PROBLEM DEFINITION

(US)AID policy statements recognize the importance of population health for economic development in Less Developed Countries (LDC). In fact, health is viewed as a crucial means for achieving the goal of economic development. McPherson notes, (McPherson, 16)

> Clearly health is a goal of economic development. A healthy population is an essential resource in the important task of nation building. Rearing well-nourished, bright students is required if investments in education are to pay off. Reducing child mortality is essential if poor women are to choose to limit the number of the children they bear.
>
> Reduction of population growth is a key to better quality of life and full development of human potential. It is critical that the labor force be given freedom from debilitating diseases and from spending large amounts of time to meet the demands of survival. Their labor must be directed to investment in a secure future for themselves and their children.

To achieve the enabling means of health, AID focuses upon three major components: a system of primary care, beneficiary share in recurring primary care costs, and research/operationalizing "... developing technology to identify, prevent and treat diseases in the Third World." (McPherson, 17)

Groups targeted for the first component, a system of primary care, are: infants and young children, the vulnerable group; women of

reproductive age; and the labor force, the economically productive group. Workable technologies for these groups include immunizations, oral rehydration therapy, family planning, elements of nutrition, growth monitoring, breastfeeding and proper weaning practices. Where local diseases contributing to health problems can be met with cost/effective technology, AID seeks to improve water supply and sanitation.

The second component of AID policy is to have beneficiaries share in recurring costs. This may be accomplished through increased direct payment, cooperative or union membership or third party payment. The objective is to reduce drain on government expenditures as well as utilize the individual resources, motivation and the traditional health system. Through this participation to implement a health program, it is felt that individuals will have a bias toward the effectiveness and success of the program.

The third component is the development of technology to identify, prevent and treat Third World diseases through biomedical research. AID seems to be locked into traditional thinking, and to have fallen into the trap of defining the problem primarily in its bio-medical dimensions. In their recent 1984 publication, Aid refers to the health care and bio-medical service dimensions as their primary targets.

Their focus on specific targets rather than a broader systems approaches suggests their bias and the limits of outsider perception to deal with fundamental health concerns. As noted by AID "A basic package of proven, cost-effective technologies delivered by primary health care programs is the heart of AID'S health strategy." (Curlin, 16)

AID'S DEFINITION OF THE PROBLEM

USAID writer Curlin, identifies the problem as one of technological stages of development. That poor populations have not, "... benefited fully from modern medicine...," and we in the West faced similar problems at our stage of economic development. This view negates the need for radical transformation of the system and postulates a reasonable linear line of health development. He notes (Curlin, 18)

> The pace of advancement in health care in developing countries - beginning with the introduction of antibiotics and modern health care - has slowed as the poorer and less accessible populations of the world have not benefited fully from modern medicine. The small gains that have been made are steadily eroded by high population growth rates. And the fragile economies of developing countries cannot pursue expensive, high-tech Western health goals.
>
> At the turn of the century, however, U.S. health statistics were similar to those of developing countries today. New York City's infant mortality rate, an indicator of the overall health of a population, was 140 per thousand live births in 1900. Diarrhea, the leading killer of children, faded from the scene because of modern plumbing, refrigeration, and adequate supplies of potable water, not because of medical advances.

Given their definition of the problem, where does AID allocate its resources? Their approach is primarily to provide more of the same, more resources, more efficiently delivered for the same general medical categories. (Curlin, 18-19)

> AID's health program focuses on the major killers of children and it promotes the use of existing technologies known to be effective in developing countries. This pared-down, action-oriented approach is our best bet for reducing child mortality. At the same time, AID is pursuing the development of new technologies to deal with problems such as acute respiratory diseases. AID also is continuing long-term efforts to control endemic tropical diseases and to provide safe water and sanitation.
>
> The Agency's priority is to provide a basic package of proven, cost-effective technologies that can be successfully delivered through primary health care programs. Oral rehydration therapy (ORT), immunizations, family planning, and simple nutrition practices - such as promoting breast-feeding, developing improved weaning foods, and monitoring the nutrition of babies - offer immediately available, effective means to reduce the death toll of infants and children.

Unfortunately, problem definition for health promotion has been made by bio-medical expertise rather than through socio-cultural understandings and perspectives.

It is unfortunate that this targeted technological approach of aid fails to integrate the new realities of health education and promotion. These new realities, can help to deal with health problems in a more contemporary and effective way. These new realities suggest the need to move from the traditional target and integrated service programs to meeting basic needs and utilizing a more effective systems approach.

The limits of the vision of medical professionals for working toward a broader goal of health care promotion are well known. (Taylor, 5)

> Trying to promote primary health care through the medical profession is like trying to promote land reform through the big landowners," says Dr. David Werner, Director of The Hesperian Foundation in Palo Alto, California, USA, one of the most vocal advocates of primary health care. The reason is that PHC is almost invariably managed by ministries staffed by doctors, yet has precious little to do with the medical profession. Doctors are not trained to sink tubewells or dig pit latrines. And, as a profession, they have rather a lot to learn about cooking mealie-meal with oil and green vegetables.
>
> The vast majority of medical institutions and practitioners are still narrowly focused on curative care - on removing symptoms.

The traditional definition and perception of health needs and expertise have affected health care services and the manpower production of those who are to deliver these services. As such it has been a corrupting influence, reinforcing limited perception, by the weight of numbers in the interest groups involved.

4. CHANGES TOWARD HEALTH EDUCATION PROMOTION

Despite this traditional medical monopoly, there has been significant movement toward a more socio-cultural or systems approach to health concerns. Health education, a component of health services has reflected this change and is being redefined from carrying out of bio-medical orders to greater participation in socio-cultural decision-making.

CHANGES IN HEALTH INTERVENTIONS

TRADITIONAL APPROACHES		MORE CONTEMPORARY APPROACHES	
MODEL 1	MODEL - 2	MODEL - 3	MODEL - 4
TARGET ORIENTED PROGRAMS	INTEGRATED SERVICE PROGRAMS	BASIC NEEDS APPROACH	SYSTEMS APPROACH
-Targets specific diseases, but -Lack of Coordination -Narrow intervention doesn't deal with multiple factors	-Deals with two or more diseases, but -Objectives multifold and diffuse -Still limited to a narrow range of policy instruments	-Deals with general and fundamental problems Food supplies, prices, improved income distribution, but -Doesn't integrate multi-sectoral activities ideologically or functionally	-Focus on problem resolution within the broader interrelated system Directed toward health promotion as permeating ideology

4. HISTORICAL CHANGES OF HEALTH MANPOWER DEVELOPMENT AND ALLOCATION

From W.W. II - 1960 there was a definite scarcity of trained personnel compared to needs in all sectors, and all additional workers who could be trained were considered worthwhile. "Since 1960 it has been evident that indiscriminate production of health workers in numbers and kinds is not conducive to harmonious manpower development, but rather may result in imbalances, underuse, and unemployment." In the health sector there developed a need to study human resources, make predictions, and--if possible--rationalize the training and use of personnel. (PAHO, Health Manpower Planning, 1)

In addition to this shift to more specification, there also has been a shift in defining "health resources." From a definition of resources as those who might enter the training as health service workers, the view was expanded in the early 1970's. "...an increasing tendency to consider the population itself and its ability to perform in health activities the primary human resource, while professional, technical, or auxiliary health workers, who would reinforce and supplement community activities, are considered the secondary resource." (PAHO, Health Manpower Planning, 1)

There have been noticeable changes in health manpower objectives which reflect this shift to a broader cultural approach. From heavy focus on "Quality of Conventional Personnel" the approach is now cultural "Relevance of Health Personnel," It has moved from quanitity to quality.

CHART 1

HEALTH MANPOWER POLICY OBJECTIVES: APPROXIMATE EVOLUTION IN WHO**

FROM 1948 TO 1980, BY TIME-PERIOD AND DEGREE OF IMPORTANCE*

OBJECTIVES	Period I 1948-51	Period II 1952-61	Period III 1962-72	Period IV 1973-80
1. QUANTITY OF CONVENTIONAL PERSONNEL	x x x	x x x	x x	x
2. HIGH QUALITY OF MEDICAL AND NURSING EDUCATION	x x	x x x	x x	
3. EQUALITY OF CREDENTIALS CROSS-NATIONALLY		x x	x	
4. GEOGRAPHIC COVERAGE IN COUNTRIES		x x	x x x	x x x
5. EFFICIENCY OF HEALTH PERSONNEL		x	x x	x x x
6. PLANNING OF HEALTH MANPOWER			x x	x x x
7. RELEVANCE OF HEALTH PERSONNEL		x	x x	x x x
8. INTEGRATION OF THE DEVELOPMENT OF MANPOWER AND SERVICES			x	x x x

* The check marks indicate approximate degrees of importance, from slightly important (x) to very important (x x x).

** Entire table taken from Fulop, Tamas, International Development of Health Manpower Policy, Geneva, WHO, 1982, p. 27

HEALTH MANPOWER POLICY OBJECTIVES (Fulop,Tamas, 31-165)

1. Quantity Objectives: To provide greater supplies of conventional health personnel (The policy of increasing conventional health personnel has been changing to the training of other types of personnel)

2. Quality Objectives: To improve personnel standards and achieve academic excellence (Quality goals, matters of national pride have assumed less importance in the current period)

3. Equality Objectives: To facilitate migratory freedom for health personnel (Current recognition that infrastructure is key to migration of skilled personnel)

4. Coverage Objectives: To provide health personnel to serve all the people (Recognition that this objective requires expanding training and programs for non-conventional, multi-purpose auxilliary health personnel)

5. Efficiency Objectives: To avoid waste in training and performance (Efficiency in performance and training of personnel have resulted in programs to develop health auxiliaries, health teams, health management, and health personnel teacher training)

6. Planning Objectives: To prepare for future requirements (Manpower planning is currently regarded as one component in production and management of health personnel)

7. Relevance Objectives: To provide appropriate training to local health needs. (Continuing struggle to increase the relevance of health personnel to society's needs)

8. Integration Objectives: To coordinate health service needs and manpower development (Generally accepted as a long term objective)

NEEDS FOR NEW TYPE OF HEALTH WORKERS

A new emphasis on self-reliance at the individual and community levels requires training health care providers to facilitate and accommodate people having a say in their own condition and having a right to know about the results of activities carried on in their own community.

The increased recognition of the need for intersectoral cooperation requires an interest and wide-ranging health education activities in all aspects of community life. This includes schools and work-places as well as homes, and activities such as nutrition, water supply, housing, communication, environmental protection, and mass media.

Reflecting these changes in a conceptual frame, objectives for training in health education should enable manpower to: (WHO, Expert Committee, New Approaches, 1983, p. 31-2)

-adopt a new outlook and be concerned not only with disease prevention and control but also with development in general and with people-oriented technologies;
-act as "facilitators" of action by the people;
-promote the two-way transfer of technologies between the health system and community;
-assume an advocacy role for the cause of health vis-a-vis both the people and the decision-makers; and
-recognize the contribution that professionals in other sectors can make to the promotion of health.
-concentrate on raising the competence of families in influencing their children to adopt a healthy life-style. To teach the families to use appropriate knowledge in bringing-up their children. In this way, health education will become an integral part of the process of socialization.

People oriented strategies suggest reassessment of manpower needs and expertise requirements at different levels. What is an appropriate level of manpower development at different levels of expertise. Health promotion might be better achieved through a targeted allocation of manpower resources and a reduction of the imbalanced appropriation for health care expertise.(Taylor, 6).

> Surgeons with specialist equipment are expensive. But a referral pyramid that is working properly might only need one or two experts at the top. Unfortunately many countries report a health service pyramid that is distinctly top-heavy-with little attempt made to slim down the greedy facilities at the apex. Not less than 80 per cent of the health budgets in the developing world is estimated to be spent doctors and hospitals.
>
> In Central and Latin America, for example, nearly 200,000 expensively trained doctors are set to don their white coats over the next six years - far more than are required. Meanwhile one million PHC workers are needed in the countryside for people who will probably never get the opportunity to set eyes on one of the bright new graduates.

Alternatives are evidently needed to the present health care delivery system.

According to Dr. Miazad (Colle, 3)

> If primary medical care is to be provided to the scattered village population, an alternative to the present health delivery system must be considered. The number of physicians is far too few to be able to provide medical coverage over so vast an area. Even if there were enough physicians, the lack of social and educational opportunities in the village for the physicians and his family would keep them away.

Changes are needed from the traditional health education model to one of participatory health promotion.

B. CHANGES FROM HEALTH EDUCATION TO HEALTH EDUCATION PROMOTION

1. THE CHANGE

As part of this conceptual change to a more socio-cultural approach, there has been a shift from the prescriptive approach of health education to the facilitating approach of health promotion. Dr. Mahler, Director General of the WHO has noted, "Health educators should see to it that they put an abrupt end to that type of health education which was concerned with telling people how to act. They should instead put all the emphasis on understanding all those social forces, anywhere in the world, that cause people to act as they do." (Mahler, Health for All)

The Alma Ata Conference in 1978, helped set the stage for a participatory approach to health education. It declared, "... people have the right and duty to participate individually and collectively in the planning and implementation of their health care, " and that one of the essential activities in primary health care is, "... education concerning prevaliing health problems and the methods of preventing and controlling them." This call for a new approach in health care was a major shift from health imposition by authority to health participation by the community.

(WHO, New Approaches to Health Education in Primary Health Care... 1983, p. 8)

IMPORTANCE OF BEHAVIORAL MODIFICATION AND EDUCATION FOR HEALTH PROMOTION

Social learning and behavioral modification should be replacing traditional authoritarian pedagody as a way to promote health. (Taylor, 4)

> Changing people's habits is potentially one of the most effective ways of promoting good health. Simply encouraging breastfeeding can avoid the malnutrition-infection short-circuit which has resulted in thousands of babies being inadequately fed on weak solutions of powdered milk in sterilised bottles. Health education in all its apsects is therefore going to play a vital role in the coming years.

The following chart has been developed to reflect the polar positions and changes from Health Education to Health Education Promotion.

SHIFT FROM HEALTH EDUCATION TO "HEALTH PROMOTION"

	EARLIER HEALTH EDUCATION	CURRENT HEALTH PROMOTION
1. BASIS	- BIO-MEDICAL - ALLOPATHIC MEDICINE - DISEASE PREVENTION	- IMPORTANCE OF SOCIAL, CULTURAL AND PSYCHO-SOCIAL FACTORS, HOLISTIC
2. ENVIRONMENT	- INFECTIOUS DISEASES - SPECIFIC 'TARGETED' ACTION	- CHANGING DISEASE PATTERNS, CHRONIC - NEW RELATIONSHIPS BETWEEN COMMUNITY MEMBERS & WIDE RANGE OF PROVIDERS
3. WAY TO BETTER HEALTH	- FOLLOW SUGGESTIONS OF KNOWLEDGE SPECIALISTS; - INTERVENTION	- PEOPLE ARE ABLE TO THINK AID ACT CONSTRUCTIVELY TO IDENTIFY & SOLVE THEIR OWN PROBLEMS
4. TRANSMISSION	- DOWNWARD TRANSMISSION OF KNOWLEDGE AND CORRECT INFORMATION - CLINICAL, PEDAGOGICAL	- PARTICIPATION AND COMMUNITY INVOLVEMENT - UP FROM THE PEOPLE
5. ROLE OF HEALTH OFFICIAL	- SINGLE ROLE: PROVIDER OF SERVICE - NEEDED EXPERTISE	- DUAL ROLE:FACILITATOR, LEARNER - DIALOGUE WITH COMMUNITY TO FIND CULTURALLY APPROPRIATE HEALTH RESPONSES
6. ROLE OF TECHNOLOGY	INDUSTRIAL MODEL INCREASINGLY LABOR & CAPITAL INTENSIVE	LINKAGE WITH PEOPLE & COMMUNITY TO FACILITATE HEALTH
7. USE OF KNOWLEDGE	GENERATE ADDITIONAL KNOWLEDGE AND NEW TOOLS	MAKE GOOD USE OF EXISTING KNOWLEDGE
8. ROLE OF EDUCATION	- TO TEACH PEOPLE THE "RIGHT" WAY - FORMAL INSTRUCTION	- EDUCATIONAL ACTIVITIES AS THE BEST WAY TO ENCOURAGE PEOPLE TO PARTICIPATE IN HEALTH CARE - NON-FORMAL LEARNING

9. OBJECTIVES OF HEALTH EDUCATION	- TEACH PEOPLE WHAT TO DO	TO INCREASE, " ... INDIVIDUAL AND COMMUNITY CAPABILITIES FOR INVOLVEMENT AND SELF-RELIANCE IN HEALTH, AND TO PROMOTE HEALTHY BEHAVIOUR, PARTICULARLY REGARDING FAMILY HEALTH AND NUTRITION, ENVIRONMENTAL HEALTH, HEALTHY LIFE-STYLES AND DISEASE PREVENTION AND CONTROL," (HEALTH FOR ALL SERIES #8, WHO, 1982)
10. ROLE OF INDIVIDUAL	BLAMES THE SICK, POOR & MISERABLE FOR THEIR ILLNESS, POVERTY & MISERY	- RECOGNIZES POLITICAL, ECONOMIC & ENVIRONMENTAL FACTORS CAN HAVE A NEUTRALIZING OR NEGATIVE EFFECT ON HEALTH BEHAVIOR
11. POLICY FACTORS	NATIONAL TARGETED PROGRAMS OF DISEASE CONTROL & FAMILY PLANNING, CARRIED OUT ACCORDING TO PROFESSIONAL VALUES & EXPECTATIONS.	- POLICIES TO ALLOW & FACILITATE COMMUNITIES TO DEFINE & PURSUE OWN GOALS; MOBILIZE OWN RESOURCES, AND CONTROL & EVALUATE OWN EFFORTS. - DISEASE CONTROL MUST FIT IN WITH COMMUNITY FRAMEWORK

THE ROLE OF HEALTH EDUCATION IN THE CONTEXT OF NEW HEALTH EDUCATION PROMOTION THINKING

Health education requires a reformulation of policies, concepts of human resources, educational technology, multi-sectoral approaches, and evaluation. (Mahler, H. "Health for All-Everyone's Concern,")

POLICIES (1) health education needs to develop new policies in harmony with the principles of primary health care and the strategy of health for all by the year 2000;

HUMAN RESOURCES (2) health education needs to facilitate the development of human resources with the skills to translate social goals into educational objectives for health for all by the year 2000;

ED. TECHNOLOGY (3) health education needs to reflect on the educational technology most appropriate to promote individual and community involvement and self-reliance; A People Orientation

MULTISECTORAL (4) health education needs to strengthen its multisectoral approach and to increase coordination of health education efforts through appropriate technology.

EVALUATION (5) health education must pay greater attention to monitoring and evaluation.

Health promotion requires more than just a cognitive knowledge of healthful ideas, it requires knowledge of structure and behavioral modification to influence the structure (Taylor, 5)

> ... good health means more than just good medicine. The causes of ill-health and the things which block the road to good health-are rooted in every part of society: in agriculture, in water supply, in education. And ultimately in politics. Primary health care is about practising something for all, not all treatments for the few; it means a radical shift away from doctor-centred medicine to a health policy that sees equality in general as the foundation of individual good health.
>
> Paying lip-service to primary health care is not enough. The political and economic changes needed to bring health to all by the year 2000 cannot easily be side-stepped.

THE NEW SOCIAL LEARNING IN A SYSTEMS APPROACH TO HEALTH EDUCATION PROMOTION

What is the long-range value of health education promotion over past practices? There is a concern that cognitive health education goes in one ear and out the other unless integrated into social education. But social education requires a broader systems context for the necessary reinforcement to take place. Health education should be seen as one of several ways to the promotion of health by preventive methods, as one of the many means that have to be used to deal with health problems. (Reid, 6)

> In the end, we really need to turn the whole question upside-down. Instead of asking how we can make health education effective, we need to start with a clearly defined health problem and identify all of the factors which can contribute to its solution. Within this framework, we can then assign a particular role to health education, but we cannot expect it to be fully effective except in conjunction with a variety of other measures.
>
> For example, improving children's dental health may require the following: controls over the consumption of sugar - perhaps affecting the sale of sweets in school shops; large-scale fluoridation of water; provision of an adequate supply of toothbrushes; education for parents; and all of these should be combined with an effective school programme. Education for children cannot be expected to achieve much by itself.

Community support also is a vital part of the support system needed in the reinforcement process for problem solving "... Major advances in health promotion cannot occur without wholehearted community support. Innumerable health schemes for schools have failed to survive the departure of outside development teams - whether the school is in the

African bush or in the urban jungles of Europe and North America."

(Reid, 7)

There is a need to base any change proposals on substantive knowledge of the community, and the children in this community. (Reid, 7)

> Finally, we need to begin from "where the children are at." We need to know their priorities - and often more important - their parents' priorities. Detailed planning has to be locally based, always commencing with surveys of existing knowledge and practice. We cannot expect to make lasting progress except by involving the community from the beginning. Otherwise, any gains made will disappear as soon as central support is withdrawn. Inevitably, progress will vary from topic to topic and country to country. But where it is possible to unite local opinion leaders and the community generally in a sustained movement for health promotion, we can indeed expect schools to make major contributions towards achieving a lifetime of good health.

What Should Be the Relationship Between Health and Health Promotion?

The WHO Working Group suggests the following relationship for more developed nations. (Regional Office for Europe, Principles and Methods of Health Education, 13-14)

- The state, and society as a whole, carried responsibility for health education, since health knowledge should form part of every individual's cultural background and health education should be an integral element of general education, aimed at improving the quality of life.

- The educational component in planning and executing national programmes concerned with health must be integrated on a regular basis and applied in a specific manner.

- In establishing health education objectives, the first essential was to study the population to be covered and to arrive at a precise determination of its health needs: those expressed, those felt, and those determined by the health services as essential to provide minimum conditions.

- Health education must be planned systematically so as to permit all those involved in developing and maintaining individual and community welfare to participate.

- If health education methods were to be improved, scientific research on the subject must be undertaken so as to arrive at an accurate verification of methods and indicators which would make evaluation of health education activities possible.

- An all-round approach using every available educational technique must be employed at the earliest possible age in order to improve an individual's awareness of health matters and health-related behaviour, including sexual behaviour.

- It was essential to ensure the participation of individuals and the community in taking care of their health. That was the ultimate goal of the educational process.

- All individuals and all responsible organizations possessing authority in the educational sphere must allocate a major priority to health education.

- Health education must be based on existing conditions and must be in line with, on the one hand, the socio-economic and cultural reality of society, and, on the other, with the progress and scientific trends in medicine.

- All medically oriented activities carried out by health teams must bring about, integrate and develop health education, which must be an integral part of all medical and social action.

- Every effort must be made to integrate health education into the individual educational process by making use of and modifying already proven existing educational methods and techniques and by carrying out research into new health education methods.

- Multidisciplinary collaboration and research must be developed so as to draw up and use a methodology which was specific, scientific, practical and suitable. Such a methodology would permit the development of health education applicable in varying circumstances.

2. INSTITUTIONAL DELIVERY SYSTEMS FOR HEALTH EDUCATION

There are at least six key institutional vehicles for changing people habits and delivering health education. These are (1)the family and primary community, (2) educational institutions (i.e., public and private schools, and colleges and universities); (3) health organizations (including voluntary health agencies, health departments and other official agencies); (4) health care facilities (e.g., hospitals, clinics, ambulatory care centers); (5) media organizations (newspaper, television, and radio); and (6) employment settings (business and industry. Each delivery system has specific types of organizational resources to employ and contribution to make in a broad ranging health promotion plan. This paper focuses on school and community settings as vital parts of the health promotion system but recognizes the role of all components in an effective system.

Community orientation is an essential component.

In the 1978 Declaration of Alma-Ata one reads that to achieve the all-important goal of primary health care community-oriented personnel will obviously be required; such care: "relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community." (WHO, Primary Health Care, Alma Ata, 5)

NEED TO UNIFY THE AREAS OF SCHOOL HEALTH & COMMUNITY HEALTH

There is a need to bridge the domains of school health and community education in the school setting (Carr, 32)

> Traditionally, health education has been conducted on the basis of a dichotomy of school health education and community health education... Those individuals contributing to health education efforts in these two areas were characteristically distinct educational species - the one having received training in a school of public health and the other in a teacher preparation program.

School age children should be considered as potential clients for both school and community health education efforts in an integrated health promotion program.

Since the time of the 1967 School Health Education Study, in the U.S.A.,(Carr, 32)

> There has been a growing awareness of the need to go beyond merely the cognitive domain of health education and to include greater emphasis upon the attitudinal or 'affective' domain as well as the development of practices and skills which are a part of the 'action' domain. Today, many health courses are being offered where personal responsibility for decisions about one's health is the focal point of the course. Projects and activities are being included which require extensive student participation in learning situations which relate directly to the student's personal health. Many of these activities involve utilization of community organizations and agencies, their personnel and/or program services in meeting individual health education needs.

COMMUNITY INVOLVEMENT AS A PREREQUISITE FOR HEALTH PROMOTION

Promoting health requires participation and involvement of the population in achieving changes. What mechanisms have been established to involve populations?

One way of accomplishing this involvement is through community health workers. (Primary Health Care: A First Assessment, 6) (?)

> Thirty-one countries have reported on efforts to involve communities, half of them by adopting policies and half through actual mechanisms, though not necessarily on a national scale. Those who claim to have set up ways and means of community involvement are Bangladesh, Burma, Congo, Democration Yemen, Gambia, Indonesia, Liberia, Nepal, Papua New Guinea, Philippines, Senegal, Sierra Leone, Sudan, Swaziland, Tanzania, Thailand.
>
> WHO reports that community-based health workers are part of the primary health strategy in most countries that have one, but the scope of their deployment is unclear.

The use and actuation of community health workers sets limits on what can be accomplished (Primary Health Care: A First Assessment, 6) (?)

> The USAID review of 52 projects finds that communities tend to support activities but not to initiate them. Community health workers have been appointed in 28 of the projects, with token payment, and at least 80 per cent of the projects have set up health committees. The review finds, however, that activities of community health committees tend to taper off once the project is under way. In many, the committees are no longer active, though this was not the case in the regional projects at Lampang in northern Thailand and at Hanang in Tanzania, nor among the Indonesian mothers' clubs or within the national Panama programme.
>
> The review found that community health workers tend to perform only a limited number of the tasks for which they have been trained. They also tend to concentrate on curative activities to the neglect of preventive and promotive functions.

THE CONTENT OF TRAINING FOR THE HEALTH PROMOTION IN THE COMMUNITY

The new health promotion should (WHO Expert Committee, New Approaches to Health Education, 32-33),

- -encourage positive attitudes among trainees in dealing with health problems;
- -take into account the relationship between living conditions and health and the influence of political, sociological, and cultural factors on individual and community behaviour;
- -provide knowledge on health cultures and the social structures of communities;
- -include methods of analysizing family participation in health care, taking into account the fact that professionals from many sectors, rather than those from the health sector alone, should be involved in promoting such participation;
- -reinforce among the trainees an awareness of the need to consider organizational and administrative factors in planning health education activities;
- -make it possible for the trainees not only to acquire scientific knowledge, but also to develop skills in transmitting this knowledge;
- -include the principles and techniques of communication- health care providers need to know how to transmit health messages effectively, and should be able to train lay persons so that they can become actively involved in health work and in motivating their community;
- -develop in the trainees an increased awareness of their social responsibility.

3. INSTITUTIONAL DELIVERY SYSTEMS: NON-FORMAL AND FORMAL SCHOOL BASED HEALTH EDUCATION

DELIVERY SYSTEM NEEDED FOR RURAL POPULATION IN DEVELOPING NATIONS

A four part program is essential if primary medical care is to be delivered to scattered populations in rural areas. This program should include health education promotion, community participation, the use of paraprofessionals, and prevention of disease and illness.

Colle notes the need and actual inclusion of a health education program. (Colle, 2)

> A recent American Public Health Association study of 180 health projects in developing countries reveals that 92% of the projects are offering some sort of health education service, indicating the serious emphasis placed on the health education component. Methods being utilized to make health education a more effective part of the primary health system include radio campaigns in Tanzania and Assam, India, effective because the use of radio can overcome geographic and literacy barriers, and audio cassette programs for both group and individual listening in Guatemala and India. A Columbian program uses cassette communication for paraprofessional continuous training and provides a simple, low cost, portable, durable, flexible, and accurate means of health education. A Guatemalan project uses cassette and record/playback systems to assist student doctors in expanding the quality and quantity of their contacts with rural people. The health education programs outlined have substantial potential but unless there is strong political commitment to the systematic use of communication and administrative record keeping, it will be difficult to implement and assess innovative health education strategies.

It is not possible to develop a "model" program applicable for all school situations. There are wide differences and variations in the on-site contexts, that should be considered in working out functional forms. (Turner, 1)

> Health problems differ sharply from one another. In some countries communicable diseases and nutritional deficiencies are chief causes of morbidity and mortality among children. In other countries they are relatively rare. Schools include the newly established multiple-class, one-teacher school in a tropical setting and the metropolitan school of hundreds of pupils in the steam-heated building of a snow-covered city. Cultural backgrounds, social customs and religious beliefs differ tremendously - as do foods, clothing, recreation, health problems, school systems and public health services.

DIFFERENCES BETWEEN HEALTH & EDUCATION PROFESSIONALS IN THE FORMAL SCHOOL

There are differences between the health and the education professionals which may result in disagreements over program priorities. (Creswell, 14)

> The difference in opinions between health and education professionals should be acknowledged. While the mission of the education professions is to help prepare children and youth for life decisions through education, the mission of the health profession is preventing illness and disability through environment and lifestyle modification, and in the early identification, referral and effective follow-up care for disease. The disagreements over program priorities caused by these different missions must be recognized and compromises worked out.

In turn, these differences may be reflected in the continuing tension between a Ministry of Health and a Ministry of Education in a developing nation; jurisdictional disputes over school health turf. In the United States this turf dispute also was and is expressed internal to the school itself. (Carr, 32)

> ... the health educator in the state or community health department setting often was working in conjunction with other health professionals in a supplemental or support role to health department programs. By contrast, the school health educator was required to be the "expert" in a self-contained sense. He or she planned and implemented the health education curriculum without consultation with other health education specialists inasmuch as there were usually no other health education personnel employed within the school setting. The health instruction program was conducted as an entity separate from other programs. Most of the educational process that occurred in schools was conducted without signficiant community input.

4. COGNITIVE BIAS IN TRADITIONAL SCHOOL HEALTH EDUCATION PROGRAMS

There has been a bias in the traditional approaches. (Parcel, 32)

> Traditional school health education programs have been based largely on a theoretical assumption that a change in level of knowledge would change attitudes, which would in turn change behavior, and eventually, habits and customs. Therefore, most formal and informal curricula have their objectives, content and evaluation grounded in information transfer. Measurement of instructional success has usually relied on tests of cognitive knowledge, although improved health behavior is the desired outcome.

This cognitive learning theory and measurement should be modified to take into account the process whereby health behaviors are learned and the resulting behavior modification. There is need for a social reinforcement dimension to increase the likelihood of behavioral modification. Parcel suggests variables affecting individual behavior modification:

The locus of control (the nature of the expectation by the individual that a particular event will occur as a result of a specific act or behavior on his part), the value attached to the consequence of an act of behavior (whether it will lead to attaining a personally desired goal). The application of this social learning theory to health suggests an individual is more likely to engage in a behavior if the outcome is viewed as dependent on their own action, and if the results of this behavior are valued (Parcel, 32-33)

Curricula implications for school health education suggest the need to reinforce an internal locus of control and to clarify the value as desirable. Focus therefore shifts from the learning of content of health related information, to the process and success of decision-making. Children are encouraged on their own to do things for themselves in regard to their health rather than having things done for them. "The use of social learning theory as a framework would change the emphasis to a type of teaching that would lead to an experience of success for children in making decisions about health-related behavior." (Parcel, 36)

The Process of Curriculum Development should include

PHASE I -

To identify the specific types of behavior related to health problems or health promotion likely to occur at that age.

PHASE II -

Determine content of what children need to understand to behave in these ways.

PHASE III -

Learning Process - What type of learning process will help children behave in desired ways.

PHASE IV -

Behavior Practice - Provide practice experience to reinforce desired behavior

The Process of self-regulation by children could follow the following model (Parcel, 36)

MONITOR	EVALUATE	MODIFY
Teach children to monitor or keep a record of health related behaviors	Teach children to evaluate what they do as to its positive & negative impacts on health	Children modify or continue behavior based on own evaluation

4. LOCUS OF CONTROL AND OTHER SOCIAL VARIABLES AS DETERMINANTS OF HEALTH

Learning as a social activity suggests that cognitive knowledge about health requires social reinforcement and support for behavioral change. Assuming responsibility for behavior related to health can be an important means for achieving health promotion objective. Traditional school health education focus on the content of health knowledge is rote learning that may pass examinations but will not in itself bring about major behavioral changes. Social learning theory suggests the value of involving the learner in initiating and activating to achieve a commonly agreed upon objective.

Roberto Belmar reported on 1975 study of the Americas which suggests, (Belmar, 3)

> a set of relationships wherein literacy, equitably distributed wealth, and democracy are among the most important determinants of the health level of a society. A statistical analysis of these variables, and their combined relationship to IMR shows that 72.3% of the variation in IMR can be explained by these factors. Of course health care and health care resources can also have positive influences on the level of health in a country, but they may be of less importance than these three factors. Studies conducted by the author have established significant correlations between health care resources and IMR for Latin America countries. But these data show that health care resources may impact far less on infant mortality than education, wealth and democracy.

Belmar notes that health is a process of continuous readjustment of interacting, social, biological and psychological demands, "whereby a person achieves well-being and, more importantly, the ability to perform useful social functions for the family, the community and the society. Health is more dependent on social factors, such as income, education and democracy, than has hitherto been believed (Belmar, 3-4)

6. SCHOOL HEALTH - THREE COMPONENTS

Traditionally school health has been divided into three components 1. Services, 2. Curriculum, 3. and environment. Yet, it is the interaction between three components that can bring about a dynamic interactive school health program. There should be interaction between educators and health professionals to developed integrated school health programs. This should include: (Nader, Editorial, 5).

> (1) ensuring access of students to primary health care services;
>
> (2) instituting health education as an integral part of student's education from preschool throughout formal schooling;
>
> (3) supporting special activities and programs to enhance the maximal performance of students with chronic illnesses and handicaps; and (4) ensuring continuity of preventive and curative health care services for students by linking schools and community health care providers. (Nader, editorial, 5)

One should add a fourth component of school community relations and integrate these on the three vital levels of elementary, secondary and teacher preparation.

Elementary and secondary schools in both rural and urban areas, and teacher education institutions are suitable targets for school health promotion The dimensions of health education on each of these three levels should consider 1. Healthful school living, 2. School health services, 3. Health instruction and 4. School - home - community relationships (Turner, 6)

INFLUENCES ON LEARNING EXPERIENCES AT SCHOOL

LEVELS	HEALTHFUL SCHOOL LIVING	SCHOOL HEALTH SERVICES	HEALTH INSTRUCTION	SCHOOL-HOME COMMUNITY - RELATIONSHIPS
TEACHER EDUCATION				
SECONDARY				
ELEMENTARY				

In addition to their local base and bias, programs should follow accepted basic principles in health education (Turner, 7)

1. General agreement that hygiene and health education should be compulsory on all levels of education including teacher education
2. The need to bridge services of public health by the Ministries of Health with school health services handled by Ministries of education. Need to establish joint committees to provide this linkage mortality and morbidity
3. Need for local input in building program. Need for flexible adaptation to local needs
4. Need to articulate education in the school, in the community and at home
5. "The pre-service preparation of teachers in health education and their further in-service training, as needed, are recognized as of great importance to the quality of health education in schools." (Turner, 9). Teachers are to be considered major health monitors and facilitators in the health process.

What Should be the Administration of Health Services in the Schools?

Wylie suggests the value in having a school health administrator in a system oversee the three health components: health instruction, health services, and healthful environment. (Wylie, 22) He notes too the need to integrate these three health components in order to vitalize the components of a school health program.

7. A CURRICULUM TO EMBODY CURRENT BEHAVIORAL THINKING ON HEALTH EDUCATION

The Self-discovery Project on innovative curriculum project developed and used in Gwinett Georgia, reflects the new involvement and discovery approach of effective social learning. Flors notes that, (Flors, 21)

> Secondary school health courses that emphasize disease information rather than wellness do not reflect current views of medicine, psychology, and education. Since adolescence is a period of life in which complex physical, intellectual, and social changes are occurring, health education programs that provide students with the necessary knowledge and skills for making thoughtful decisions about their health and that address the psychosocial dimensions which predispose individuals to engage in healthy behaviors are particularly important.

Through a 12 week course of 18 modules, developed through doing involvement, problem solving and decision-making, the student should develop the following skills

- Personal skills that the students learn and practice include:
- Identifying personal health attitudes, needs, values, and behaviors;
- Identifying and expressing feelings;
- Learning stress management techniques;
- Enhancing self-esteem;
- Selecting and interacting with a doctor;
- Knowing when to use self-care and when to seek professional help;
- Knowing what to do in an emergency using community resources;
- Changing a habit (increasing activity, improving nutrition, weight management, smoking cessation, stress management). Interpersonal skills that the students learn and practice include:
- Decision-making about sexuality, substance abuse, and parenting;
- Assertiveness;
- Evaluating health advertising;
- Communication

A more comprehensive K-12 health education program is the "Health Skills for Life" used in Eugene Oregon. (Terhune, 27)

> The program emphasizes lifelong skills for health. There are 118 individual teacher packets (called learning units) K-12, each of which is centered on one specific health skill. Skills include actual health behaviours such as dental flossing, but also include higher cognitive skills such an analyzing, comparing, classifying, interpreting, predicting and evaluating. Many of the cognitive skills center around planning, problem solving, and decision making.

The program includes ten major content areas on the K-12 levels and units integrating participation and social learning.

THE TANZANIA SCHOOL HEALTH PROGRAM

An additional curricula which embodies this health promotion thinking is in Tanzania.

This pilot program, started in 1982 attempts to utilize school professionals, and the educational structure as a means of promoting health. (Berger, Ian, The Tanzania School Health Program, 95)

> It was conceived as an opportunity to progress toward maximizing human resources in health in Tanzania by extending the health promoting capabilities among professionals whose ordinary job is not health care - namely teachers. Next to the health system is an elaborate structure for providing education to primary school students throughout the country. This structure was already in place and functioning well. A main objective of the School Health Program was to make use of the educational system as still another means for promoting health and resolving problems associated with a poor environment or lack of knowledge about health.

The goals of this program include,(Berger, Ian, 95)

1. To improve the health of Tanzanian primary school children through first aid, preventive, care, health education, safe water, sanitation and improved school farms provided at the schools;
2. To extend these benefits to the schools' villages by community participation, child-to-child extension and public education;

and to use this as a pilot program.

Objectives of this program include health care services, healthful living skills, linkage with community health needs and providing for professional training and are operationalized with the following specific objectives:(Berger, 95)

1. to develop educational materials that could be utilized on a very wide scale;
2. to teach and promote first aid, screening and preventive care and health education provided by primary school teachers to students in approximately 800 primary schools of the Dodoma and Singida Regions;
3. to develop better, potable water supplies and human waste disposal at 80 selected schools, linking these activities to the villages;
4. to inform communities, officials, professionals and the public at large about the Tanzania School Health Program;
5. to train selected Ministry of Health staff in health administration and school health;
6. to develop a lasting replicable logistic and support system for the Tanzania School Health Program;
7. and finally, to plan for a national expansion of the Tanzania School Health Program.

INTERSECTORAL ADMINISTRATION

Through the above operations, the school health program becomes part of a coordinated health development effort, and the education function becomes an integral aspect of the health promotion program. Administatively, the Ministry of Health is the dominant agency and works through a National Director of the School Health Program. The staff for this National Director is guided by an Interministerial Council on School Health with representatives from Ministries of Health, Education, Water, Agriculture and Planning Ministries .

Baseline information is provided for the 80 schools in the two school districts in the pilot program, and changes are noted in children's and families health.

BRAZILIAN EXPERIENCE

A health curricula, this one in Brazil expands the traditional approach.

The Brazilian experience and failure with the Prevsuade program suggests the need to view health promotion from a multi-sectoral approach and to deal with health in the broader political context of social change. (de Macêdo)

> Many health care professionals - even well meaning ones - have fallen into the trap of 'medicalising' health, which masks the continuing socioeconomic determinants of health and disease; and they have thereby contributed to brain-washing the population into believing that health care is a sufficient condition for achieving health. In future health policy must not be limited to health care organisation, which is only one focus of the former. It must be clarified how, and to what extent, the socioeconomic determinants of illness will be dealt with in the social and economic spheres. Health care services will then appear as just one of the measures that must be adopted to promote, protect and restore health.

8. THE ROLE OF TEACHER TRAINING INSTITUTIONS IN DEVELOPING TEACHERS AS HEALTH AGENTS

What should be the function of the classroom teacher in school health education? Some general role assumptions are suggested in the UNESCO publication. (Turner, 106-110). The teacher should facilitate healthful school living to include cooperating to maintain hygienic and sanitary working conditions at the school; and helping to develop sanitary conditions and protective practices with respect to water supply and waste disposal. Also, the teacher should observe children daily for health status (primary school), and help to maintain sanitary and hygienic conditions.

In regard to school health services, the teacher should be involved in the program for the prevention and control of communicable disease, including exclusions and readmittance to school; prepare children for health examinations and other school health services by developing proper understanding and attitudes on their part; understand and carry out effectively any screening procedures assigned to them, such as tests for vision and hearing; cooperate effectively with whatever health specialists serve the school (physicians, dentists, public health nurses, dental hygienists, psychologists, nutritionists, social workers), and refer children, where needed.

In regard to instruction in health the teacher should use a variety of suitable learning experiences and materials adapted to the developmental levels of pupils; utilize pupil experiences in healthful school living and in relation to school health services to provide some of the health teaching content; use pupil, family and community health problems as a part of health instruction; and furnish an example of healthful living.

In regard to school, home, and community relations, the teacher should assist in interpreting the program of school health and health education to the home and in developing parent-school co-operation.

If teachers are to assume these health agent roles in the classroom, their training should include skill development in competencies needed to achieve the objectives.

SUMMARY

Health education promotion is clearly an idea whose time has come. It embodies the "in" language for change agents who wish to improve health of populations, and reflects ideas consistent with current ideology and pronouncements. Clearly dealing with health problems in developing nations requires fresh and more effective strategies. Language itself, however, will not solve the problems. The development of effective strategies and infrastructures is essential.

Belmar, Roberto, "Research Statement on Democracy and Other Social Variables as Determinants of Health," Comparative Health Systems Newsletter, Vol. 5, No. 1, March 1983, p. 3

Berger, Ian, Ngaliwa S., "Mradi Wa Afya Masuleni" The Tanzania School Health Program, The Journal of School Health, Vol. 53, No. 2, Feb. 1983, p. 95-98

Carr, Marion T., "School and Community Health Education: A Move Toward Unity," Health Education, March/April 1983, p. 32-35

Colle, Royal D., "Developing Health Education Programs in Rural Areas," Paper prepared for the 2nd International Federal of Public Health Associations, May 23-26, 1978, 18p., ERIC-RIE, ED 182-082

Cresswell, William H., "Quo-Vadis-Health Education," Health Education, July/August 1982, p. 12

Curlin, George, "Building for a Healthy Tomorrow," Horizons, Spring 1984, p. 16-22

de Macedo, Carlyle G. and Cesar de B. Viviera, "The Fate of Primary Care in Brazil," Bulletin, Institute of Development Studies, Vol. 14, No. 4, 1983

Flors, Stuart W., Patricia Gibson and Gilda Gussin, "Evaluation of the 'Self Discovery' Health Curriculum Project: A Case Study," Health Education, May/June 1983, p. 21-24

Fulop, Tamas, International Development of Health Manpower Policy, Geneva, WHO, 1982

Gillis, Malcolm, et. al., "Health," in Economics of Development, New York, W. W. Norton, 1983, p. 232-257

Green, Lawrence and K. Johnson, "Health Education and Health Promotion," in Mechanic, David, ed., Handbook of Health Care and the Professions, New York, Macmillan Co., 1983, p. 745-765

Mahler, Halfdan, "Bringing Down the Medical Empire," PAHO - HEALTH, Vol. 10, No. 1, 1978, p. 10-15

Mahler, Halfdan, "Health For All - Everyone's Concern," WHO - World Health, April-May 1983, p. 2-5

McPherson, M. Peter, "Aid's Pillars of Health," Horizons, June 1983, p. 16-18

Nader, Philip, "School Health: The Potential for Altering the New Morbidity," Health Values: Achieving High Level Wellness, Vol. 4, No. 1, Jan./Feb. 1980

Parcel, Guy S., Philip Nader and Peggy Rogers, "Health Locus of Control and Health Values: Implications for School Health Education," Health Values: Achieving High Level Wellness, Vol. 4, No. 1, Jan./Feb. 1983, p. 32-37

Pan American Health Organization, Health Manpower Planning, U.S. Dept. of Health Education and Welfare, 1979, 166p.

Regional Office for Europe, Principles and Methods of Health Education, Report on a WHO Working Group, Copenhagen, WHO, 1979, 17p.

Regional Office for Europe - WHO, Primary Health Care - from Theory to Action Report on a WHO Symposium, Copenhagen, WHO, 1982, 29p.

Reid, Donald, "Learning Good Health," World Health, Jan.-Feb. 1984, p. 5-7

Taylor, Debbie, "The Chance of a Lifetime," WHO - World Health, Sept. 1983, 11p.

Terhune, James A., and Joan Shaughnessy, "Health Skills for Life," Health Education, September/October 1983, p. 27-31

Turner, C. E., Planning for Health Education in Schools, Unesco Source Book, New York, Longmans, 1966, 157p.

WHO Expert Committee, New Approaches to Health Education in Primary Health Care, Geneva, WHO, 1983, 45p.

WHO, Primary Health Care, Alma Ata, 1978, Geneva, World Health Organization, 1978 (Health for All Series, No. 1)

World Health Organization, Evaluation of School Health Programmes by a Working Group, Copenhagen, World Health Organization, 1978

Wylie, Wayne, "School Health Administration; A Proposed Model of Organization Within the School Setting," Health Education, March/April 1982, p. 22-24